DOCUMENT RESUME

ED 318 934 CG 022 479

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TITLE The Assessment of Emotional Distress in Personal Injury Litigation.
PUB DATE May 90
NOTE 57p.; Doctoral research paper, Biola University.
PUB TYPE Information Analyses (070) -- Dissertations/Theses - Doctoral Dissertations (041)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Court Litigation; *Emotional Problems; *Evaluation Methods; *Injuries
IDENTIFIERS *Expert Witness

ABSTRACT

This document asserts that civil litigation of personal injury claims involving emotional distress is commonplace in American society today. It recognizes that expert witness testimony often plays a key role in the rewarding or denial of damages in such claims and that the psychologist's role as an expert witness in such matters entails unique challenges and considerations. Findings from a literature review are presented to assist the psychological practitioner in gaining an understanding of the assessment process relative to civil litigation involving emotional distress claims. An overview examines psychological and legal definitions, traces the history of emotional damages in personal injury litigation, and follows the evolution of the psychologist's status in the courts. Specific issues of the diagnostic process, the determination of malingering, and the use of psychological tests are discussed. Recommendations for the application of the findings and further research are offered. (Author/NB)

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ED318934

THE ASSESSMENT OF EMOTIONAL DISTRESS IN PERSONAL INJURY LITIGATION

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Brent Roderick Smith

May 1990

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THE ASSESSMENT OF EMOTIONAL DISTRESS

IN PERSONAL INJURY LITIGATION

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ABSTRACT

THE ASSESSMENT OF EMOTIONAL DISTRESS

IN PERSONAL INJURY LITIGATION

by

Brent Roderick Smith

Civil litigation of personal injury claims involving emotional distress is common place in our society today. Expert witness testimony often plays a key role in the rewarding or denial of damages in such claims. The psychologist's role as an expert witness in such matters entails unique challenges and considerations. This review is intended to assist the psychological practitioner in gaining an understanding of the assessment process relative to civil litigation involving emotional distress claims. An overview will examine psychological and legal definitions, trace the history of emotional damages in personal injury litigation, and follow the evolution of the psychologist's status in the courts. Specific issues of the diagnostic process, the determination of malingering, and the use of psychological tests will be discussed. Recommendations for the application of the findings and further research will be offered.

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ACKNOWLEDGMENTS

I would like to acknowledge the individuals who have been so helpful and supportive to me throughout this venture: my readers, Dr. Tony Wong and Dr. Martha Rogers, for their vital input and guidance despite the demands of both the academic and private arenas; Dr. William Hunter, for his valuable editorial input; Dr. William Edkins, whose wisdom and support were continually encouraging; Susan Herring, for her hard work in the publication of this manuscript; finally, my wife, Linda, for her patience, understanding and love.

DEDICATION

I would like to dedicate this paper to my father, Dr. Roderick J. Smith, whose life has instilled in me a love of learning and the desire to meet a challenge.

The Assessment of Emotional Distress in Personal Injury Litigation

Introduction

Civil litigation is a present reality in our society today. It is difficult to read a newspaper without encountering an article about one person or group suing another for some alleged wrong or damage. When a person is wronged by another, his or her legal avenue of recourse is through civil litigation. The area of civil law concerned with such wrongs, except those arising from contracts, is tort law. In torts of negligence, financial damages are sought not only for the material losses resulting from an incident, but for damages in compensation for the physical pain and suffering as well as emotional distress caused by the wrongful act. This distress may or may not accompany an actual physical injury and may or may not express itself in physical symptoms.

In determining damages for emotional distress where a tort has occurred, the role of the psychological expert is not only helpful, but vital. The psychologist's role in the assessment of emotional distress entails unique challenges and considerations. The psychologist may testify on behalf of the plaintiff in attempting to establish the existence of emotional distress, or on behalf of the defendant, in attempting to identify a litigant who may have exaggerated his or her claim of injury or be malingering. Furthermore , the courtroom is a vastly different arena than that to which most psychologists are accustomed.

The purpose of this review is to assist the psychological practitioner in gaining an understanding of the assessment process relative to civil litigation involving emotional distress claims. Emphasis is also placed on differences from ordinary clinical practice. This is approached by providing an overview of the topic and an examination of the literature pertaining to specific issues in the assessment process. The overview examines psychological and legal definitions, traces the history of emotional damages in personal injury litigation and follows the evolution of the psychologist's status and role in the courts. The specific issues addressed include the diagnostic process, the determination of malingering, and the use of psychological tests. Finally, recommendations are offered for the application of the findings and for further research.

History and Evolution of Emotional Distress Claims

Current Definitions

As stated above, the area of civil litigation concerned with compensation for personal injury is tort law. Tort is a term whose origin is found in the Norman word for "wrong." Prosser (1971) listed a broad range of civil wrongs which are presently considered torts. These include negligent conduct, intentional as well as negligent infliction of emotional distress, assault and battery, defamation of character, sexual harassment, false imprisonment, malpractice, and product liability when personal injury results. Thus, since its emergence, tort law has been concerned with the problem of determining civil responsibility for injury.

A common element in a tort is the suffering that an individual experiences due to

an injury. Damages for pain and suffering resulting from a personal injury compensate an individual for physical pain and disability and for the mental consequences of the injury. These consequences may include compensation for pain itself, the emotional shock encountered during the injury, fear of death or severe injury that accompanies or follows an injury, anxiety and depression associated with the inability to support one's self or family, adverse changes in personality and lifestyle, and fears of continued physical deterioration or permanent diminished health. Mental suffering damages also form an integral part of recovery in other causes of action. In wrongful death actions, most jurisdictions do not permit survivors to recover damages for normal grief or suffering. An exception to this is when a survivor witnesses a traumatic death of a loved one, which is usually compensable. Many jurisdictions, however, do permit survivors to recover for loss of society and comfort, love, companionship, guidance, and advice.

Case History

The legal standard for the recovery of damages in tort law is established over time by precedents set in various cases. To understand the present status and standards for recovery in cases of personal injury involving emotional distress, it is necessary to note the significant cases which set the precedent for such recovery. Smith (1984) asserted the need for general guidelines for establishing recovery rather than the use of arbitrary legal tests. He writes; "Courts have made substantial progress in permitting just recovery for the negligent infliction of emotional distress. Unfortunately, some states have still not embraced this concept, and many that have, have established artificial and mechanical tests" (p. 34).

Personal injury litigation became common place during the second half of the

nineteenth century with the popularity of railway travel and ensuing accidents. Many of these personal injury actions included emotional damages as part of the physical injury claim . Damages for emotional symptoms in the absence of a physical injury were denied by the courts until the early years of this century (Mendelson, 1988). One exception was that of a fourteenth century English case which allowed for recovery without concurrent physical injury. In this case, an innkeeper's wife experienced extreme fright when a customer threw a hatchet at her. This precedent was not followed during the nineteenth and early part of this century when there was an abundance of railway accidents attempting to claim personal injury based on symptoms due to fright. Mendelson explained this apparent discrepancy by the fact that claims made following railway accidents were made on the basis of negligence whereas the case cited above involved a willful act.

Schumann (1986) suggested that the reason common law has been weary of permitting recovery from mental or emotional injuries alone is that without demonstrably verifiable injuries, a risk of fraud is posed to which the courts could not effectively respond. A plaintiff may recover damages from mental and emotional injuries if these are related proximately to compensable physical injuries. He stated the following reasoning for this:

> The presence of related physical injuries serves two purposes. First, the physical injuries are thought to provide some safeguard against fraud by demanding some demonstrable evidence that the plaintiff has actually been injured. Second, courts have come to accept that physical trauma may have an emotional consequence, and are, therefore, more willing to permit recovery in these instances. (p. 323)

Attempts to recover from mental or emotional injuries sustained in the absence of physical impact is another story, and courts initially denied such claims

(Magruder, 1936). The courts held that emotional pain and anguish were too vague for legal redress (White, 1980). Prosser (1971) pointed out that it was not until the 1930s that emotional distress without accompanying physical injury began to attain independent status. The assertion that mental suffering constituted as real an injury as physical pain began to be an established doctrine of court law.

The first form of relaxation of these restrictions was in cases involving intentional rather than negligent infliction of emotional distress. Subsequently, in most jurisdictions the limitations have been relaxed in cases of negligent infliction of emotional harm. In the case of Molien v. Kaiser Hospital (1980) the concept of negligent infliction of emotional distress came to be recognized fully as an independent tort. The court in Molien showed that emotionally traumatic effects of an injury are amenable to objective ascertainment and that the authenticity of the claim can thereby be corroborated. Legal standards would permit recovery where proof of emotional distress is of a psychologically significant nature and where there is some guarantee of genuineness in circumstances of the case (Schumann, 1986). The Molien case also emphasized the issue of foreseeability. This requires that the incident in question have a foreseeable negative impact on the individual.

Schumann (1986) went on to explain, "One approach has been to permit recovery for emotional harm in the absence of a physical impact when the emotional consequences are accompanied by some physical or objective evidence corroborating the emotional disorder" (p. 326). Other jurisdictions have abandoned the requirement of physical impact or objective consequences and have focused instead on proximate causation as a limitation on the range of liability producing events. One such case was Paugh v. Hanks (1983). Here, the requirement for physical injury or objective evidence of the plaintiff's emotional distress was rejected

while requiring the plaintiff's emotional distress be serious. This was a deviation from previous cases (see Dillon below) which required that the plaintiff's emotional distress be manifested in some physical form. In Paugh, the court also permitted recovery for incidents which occurred over a period of time versus a single event.

Rodrigues v. State (1970) provided for recovery for emotional distress when a reasonable person would be unable to adequately cope with the mental stress engendered by the circumstances of the case. This again asserts the requirement of severity of emotional impact which exceeds that which would be normally encountered in life. The recognition of the right to recover from emotional injuries without accompanying physical impact or consequence relies heavily on the assumption that psychiatrists and psychologists can verify the legitimacy of such claims (Schumann, 1986). This task of verification of the legitimacy of the injury poses special problems and will be discussed in further detail later.

Another area of injury due to emotional distress is that of bystander recovery. This is where an individual claims damage from emotional distress due to observing a traumatic event. As in recovery for emotional distress in general, courts have been cautious to grant recovery for bystanders. In the case of Dillon v. Legg (1968) a significant precedent was set for bystander recovery. This was a case where a mother saw her young daughter killed by an automobile. These precedents were:
(a) proximity, whether the plaintiff was located near the scene of the accident as contrasted with one who was a distance away, (b) sensory impact, whether the shock resulted from a direct emotional impact upon the plaintiff from the sensory and contemporaneous observance of the accident as contrasted with learning of the accident from others after its occurrence, and (c) relatedness, whether the plaintiff and the victim were closely related as contrasted with an absence of any relationship

or the presence of only a distant relationship (Smith, 1984). While these requirements affect whether a plaintiff may or may not recover for damages, they are issues left for the attorneys to prove, although as part of the assessment the psychologist would attempt to ascertain what the plaintiff actually saw, heard, and felt. An understanding of subsequent post-traumatic stress disorder symptoms requires a full understanding of the plaintiff's perceptual, cognitive and affective experiences. Therefore, it is important in such cases, for the psychological expert to be acquainted with the legal standards for recovery.

The Dillon case rejected the previously held requirement of zone of danger. "This rule required a bystander to be in a zone of physical danger and have reasonable fear for his or her safety, because of the defendant's negligence before he or she can recover" (Smith, 1984, p. 36). The mother in the Dillon case was in no physical danger herself from the car that killed her daughter. While this rule was upheld in Ricky v. Chicago Transit Authority (1983) it was not required in Dillon and subsequent cases.

While the above cases dealt primarily with accidental injury, additional cases have shown recoverability in other areas of negligence. Medical negligence, product liability, and government liability are areas where bystander recovery has been granted due to damages sustained from emotional distress. Other areas where emotional distress has been the grounds for recovery are outrage and intentional infliction of emotional distress, breach of contract, suffering and loss of dignity, pre-impact suffering and distress, and bad faith by insurance companies (Smith, 1984).

As a result of these cases, tort law permits recovery for personal injury from emotional distress in a broad range or intentional and negligent actions. The

standard does not require the emotional injury to accompany a physical injury, nor does it require the emotional injury to be manifest in physical terms or for the plaintiff to be the one directly injured, as in the case of bystander recovery. The precedent requires the emotional injury to be genuine and extreme, proximately related to the event, and the potential harm to be foreseeable to the plaintiff in order to recover for damages suffered. The psychological expert can be especially helpful in addressing the first two points of establishing the presence of a genuine emotional injury and its relatedness to the event.

Admissibility of Psychological Testimony

As noted above, the courts have been slow to acknowledge emotional distress as a compensable claim in personal injury litigation, with or without accompanying physical injury. The evolution of the admissibility of the testimony of psychologists in such matters has been even slower. Psychiatric testimony has long been permitted in cases of emotional distress due to psychiatrists' membership in the medical community. Until the latter part of this century, psychiatrists were considered the only experts who could testify in regards to these issues. This is interesting in light of the poor reliability and validity of psychiatric assessment and diagnosis in clinical and forensic settings (Ziskin & Faust, 1988). As emotional distress came to stand on its own as a bona fide basis for recovery, further scientific scrutiny was needed to establish such injuries. The growing data base of psychological testing and subsequent research has helped to fill this gap. At the same time, psychological testimony has been slow to win recognition in the legal community.

As early as 1909, Muensterberg suggested that psychology had much to offer American jurisprudence. His claim was shunned by legal scholars at the time

because of limited scientific support (Wigmore, 1909). Terman (1931) resurrected Muensterberg's position and suggested that the use of psychology in the courts be reconsidered in light of developments in the science of psychology which had taken place subsequent to World War I. While dialogue was occurring during this time in regard to the potential contribution psychology offered the legal field, there remained no legal precedent for the admissibility of psychological testimony.

In the case of Frye v. United States (1923) the standard was established that "to be admissible, the evidence should be generally accepted by the scientific community of which the expert claims membership" (Blau, 1984, p. 176). While this position predates the admissibility of psychological testimony, it clearly set the standard which psychologists must meet to be qualified as expert witnesses.

It was not until the landmark case of Jenkins v. United States in 1962 that psychologists came to be recognized as expert witnesses. The standard established was that psychologists' testimony was admissible on matters within the scope of their competence. This precedent was confirmed in the case of People v. Davis (1965).

Perlin (1980) asserted that there is no question that many psychologists qualify as experts in American courts today. The cases cited above provide the precedent for psychologists serving as expert witnesses in the courts. The standard is that their testimony be on matters within the scope of their competence. While this has opened the door for expert psychological testimony and the use of psychodiagnostic instruments in the courts, it requires a high standard of scientific scrutiny to stand against often hostile cross-examination. For example, Ziskin and Faust (1988) have written on specific strategies to assist an attorney in discrediting a psychologist's testimony.

The Role of the Psychologist

Having shown the precedent for psychological testimony in the courts, the next issue concerns the psychologist's specific role and function in personal injury litigation where emotional distress is claimed. Weissman (1985) stated:

> In personal injury cases, the critical role of the psychological examiner is to assist the trier of fact in determining whether claimed mental and emotional impairments have been caused proximately by the incident and, if so, the range and severity of its consequences on adaptive functioning in areas of a person's life that are (had been) salient. . . .Not just any events, determinants or client characteristics are legally relevant, but rather only those that are proximately related. Thus, coexisting stress factors, as well as preexisting impairments, secondary gain motivations, and factors associated with malingering must be parcelled out or ruled out, in the ascertainment of substantiality and genuineness of the traumatic effects of a claimed injury. (p. 140)

Proximate cause is a legal concept, not a psychological one. The law is concerned with whether a substantial relationship exists between a breach of duty and an injury. Schumann (1986) also emphasized the issue of proximate cause and stressed that the ability to support a claim from mental and emotional injuries depends on the nature of the relationship between the accident and the injuries. This is especially important if the relationship is not a matter of common knowledge likely to be possessed by the average judge or juror. Furthermore, the degree of certainty expressed by the witness concerning the relationship of the accident to the psychological injury is an important factor.

The three primary issues to which the psychological expert is most likely to testify can be expressed easily in question form: (a) Is there evidence of genuine emotional distress? (b) Is there evidence that the distress was caused by the event in question? and (c) How much certainty is there of the relationship? In psychological terms, the first question deals primarily with the existence of a psychological

disorder and the expert's confidence in the genuineness of the symptoms. The second question speaks to the etiology of this disorder and the need to show a causal connection to the incident in question. The third question speaks to the degree of scientific certainty in both the diagnosis and causal relationship.

Weissman (1985) likewise presented a series of questions which the expert should address:

> A) The extent to which the accident or exposure constitute a substantial factor in causing a new disorder or aggravating or accelerating a preexisting disorder. B) Whether a disorder would have occurred at all but for the event. C) The relative contributions to the presented disorder of proximate, preexisting and coexisting factors. D) The extent to which a preexisting disorder in its natural progression or evolutionary course would have resulted in the observed impairments in the absence of the event. E) Whether motivational factors associated with malingering and secondary gain are present. F) Whether a factitious disorder is present whereas psychological symptoms are being voluntary produced and presented where the goal is to assume the patient role. (p. 138)

Lasky (1983), in addressing the psychiatrist's task in worker's compensation cases, encouraged use of the following questions: (a) Is there a mental disorder? (b) Is it the result of industrial causation in whole or in part? (c) If there is a mental disorder, what is the diagnosis in terms of DSM-III? (d) State the factual findings you have made which support your diagnosis. While the context of worker's compensation cases is different from personal injury cases, the criteria here are applicable to both.

Nussbaum (1973) has noted that, in addition to making the diagnosis, the psychiatrist making an assessment of a litigant should make an objective evaluation of the degree of psychiatric impairment. Such an objective assessment of psychiatric impairment is possible if a standardized review of specific areas is utilized. Issues

such as effective intelligence, affective status, and reality contact need to be assessed. "This method of evaluation of impairment places a reduced emphasis on the psychiatric diagnosis while it takes into consideration the individual social coping skills and level of overall functioning" (Mendelson, 1988, p. 32).

The issue of certainty is crucial in legal testimony and it is important to differentiate between legal and scientific terminology. The legal standard is that the expert must assert his findings with reasonable scientific certainty. This is not the same as confidence levels which are typically held as a standard in the scientific community (i.e., alpha levels of .05 to .01). Reasonable scientific certainty in the legal context has the meaning of more likely than not, and is more analogous to scientific confidence levels of 51% rather than 95% certainty. At the same time, the expert must show more than a merely plausible relationship, which may be excluded by the court if not given with reasonable scientific certainty. Weissman (1985) expanded on this issue of certainty:

> In personal injury litigation it is necessary to determine if event A plays a substantial role in producing effect B at a level of probative value where the preponderance of evidence standard is met. . .Provitive standards for ascertaining 'truth value' are analogous to significance levels and confidence limits in the behavioral sciences. Both imply probabilistic reasoning, as does the 'reasonable scientific certainty' standard, to which experts are held. . . .The expert's obligation is to describe findings and to provide and document diagnostic formulations at a level of probative value that attains the 'reasonable scientific certainty' (more likely than not) standard. . . .The expert, as well as the lawyer, must recognize that neither absolute certainty is necessary (or possible), nor are burdens of proof representing higher probative standards (i.e., beyond a reasonable doubt, clear and convincing) relevant. (p. 141)

In summary, the psychologist's role is to attest with reasonable scientific confidence as to the genuine existence of a psychological condition, to give an opinion as to the extent and severity of this condition and its functional impact on

the individual's life, and to what degree the condition is attributable to the cause being claimed. The psychologist should ground his testimony in documentable and empirically verifiable findings which relate functionally to the psychological issues.

Diagnostic Issues

As stated above, one of the primary tasks of the psychologist in assessing emotional distress is to determine if actual emotional damage or distress exists. One aspect of this is the determination of faking an illness known as malingering which will be discussed in detail later. The existence of emotional damage and/or distress is best established if a plaintiff has symptomatology consistent with commonly recognized disorders.

Diagnostic Categories

There are three broad categories of disorders which are recognized by the courts. The first category is physical disorders such as head trauma, spinal injury or toxic conditions. The second is disorders which are entirely functional in nature with no somatic components. The third is disorders reflecting psychophysiological impairments, where emotional, physiological, and somatic factors are involved (Weissman, 1985). The first category of disorders is best assessed by medical practitioners although neuropsychological assessment may be appropriate in cases of head trauma and suspected brain injury. It is also not unusual for a secondary emotional distress to be present with such injuries in either the victim or his or her family (Luria, 1972; Lezak, 1983). The second and third categories can best be

addressed by expert psychological testimony.

An objective and consistent method of diagnosis is imperative to the process of determining if emotional damage to an individual exists. The importance of using a specific diagnostic system in medicolegal practice has been emphasized by Perr (1984). Mendelson (1988) also encouraged the use of specific diagnoses consistent with the generally accepted nomenclature as did Lasky (1980) in encouraging the use of "standard medical concepts." The standard recognized diagnostic reference used in both psychiatry and clinical and forensic psychology today is the Diagnostic and Statistical Manual of Mental Disorders (3rd. ed., rev.)(1987). The DSM-II I-R allows for a multiaxial diagnostic system, taking into account disorders manifested by a clear constellation of symptoms. Other axes allow for diagnosis of long-standing patterns relating to a person's character formation (personality disorders), physical conditions, a rating of psychosocial stressors, and a global rating scale of adaptive functioning over the past year. The diagnostic criteria in the DSM-III-R are clear and operationalized so as to promote consistent diagnostic conclusions. Weissman (1985) also encouraged the use of the DSM-III-R in that it is helpful in substantiating the harm suffered in terms of emotional, cognitive, and behavioral functioning rather than in vague complaints.

Mendelson (1988) analyzed various diagnoses in a group of 820 personal injury litigants referred for psychiatric assessment. He found that the most frequent diagnoses were adjustment disorder, mixed anxiety/depressive reactions, generalized anxiety disorder, psychogenic pain disorder, and depressive reactions. It is somewhat surprising that post-traumatic stress disorder (PTSD) was not more prevalent in Mendelson's analysis. This may be due to the possibility that some of the records examined predated the inclusion of PTSD in the DSM-III, or a diagnostic bias on

the part of the clinicians involved.

The single diagnoses which most fits the issue of emotional distress due to a traumatic event is post-traumatic stress disorder (PTSD). The essence of PTSD is the presence of an anxiety reaction after the experience of an event which is outside the range of usual human experience and that would be markedly distressing to almost anyone. There is a striking similarity between the DSM-III-R definition and the legal standard, that is, that the severity of emotional impact exceeds what is normally encountered in life. The general behavioral criteria for the disorder include: (a) the experience of a traumatic event, (b) persistent reexperience of the event, (c) persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, (d) persistent symptoms of increased arousal, and (e) duration of these symptoms for at least one month. The complete list of behavioral criteria for PTSD are listed in DSM-III-R (1987).

Some of the other less encountered diagnoses can have particular value in litigation cases where symptoms may be somewhat mixed and confusing. The diagnosis of psychological factors affecting physical conditions allows the clinician to note that such factors may contribute to the exacerbation of physical disorders.

The diagnosis of somatoform pain disorder will allow for the specific diagnosis of patients with disproportionate disability or persistent pain whose symptoms cannot be attributed to a demonstrable organic cause. Conversion disorder would be another alternative in this case. Mendelson (1988) argues that these legitimate diagnostic categories are more appropriate than the non-medical term of compensation neurosis which has been used to attempt to explain, in a biased manner, similar symptomatology. The idea of compensation neurosis is that the litigation process itself creates a condition with psychiatric features which is

alleviated once the litigation is settled and resistant to any intervention apart from settlement.

Allodi (1974) has drawn attention to the essential similarity between patients labeled as having developed an accident neurosis and the diagnosis of hysteria. Mendelson (1988) has emphasized the need to recognize that these patients may have a hysterical conversion reaction, a condition initiated and maintained by multiple determinants. A more detailed examination of the patient's life situation should help establish the factors responsible for the perpetuation of symptoms rather than assume that the pecuniary gains related to compensation is the sole motive. Again, the use of clear and standardized diagnostic criteria, such as those found in the DSM-III-R, is essential in clarifying such issues.

The diagnosis of organic brain syndrome or a mood disorder may be appropriate for some patients who complain of emotional symptoms in the absence of any significant physical complaints or disturbances. Possible differential diagnosis in this area would include adjustment disorder or post-traumatic stress disorder.

Other Diagnostic Considerations

Ludwig (1982) described another group of patients which may present a combination of somatic and emotional symptoms which defy attempts at a precise delineation and classification. He found that such individuals frequently come from a deprived socio-economic background and show chronic anxiety with some mild depressive symptoms. He also noted that these patients show an abundance of illness behavior which is superimposed over a personality structure that tends to be passive, dependent, asocial or inadequate.

Cartwright and Kassel (1988) suggested the need to consider psychosocial factors

in evaluating emotional damages in personal injury cases. They asserted that the ability to function within family, work, and social relationships must be evaluated to develop a full picture of the psychological damages. A psychosocial evaluation compares a person's lifestyle, attitude, behavior, and mood at home, at work, and in activities before and after an injury. A person's psychological make-up and social environment strongly affect the degree of emotional damage. Cartwright and Kassel also suggested interviews with the plaintiff's family, friends, and co-workers as well as community leaders, supervisors, church leaders, teacher and physicians where relevant. This psychosocial history would also consider relevant records such as depositions, medical records, psychiatric or psychological reports or notes, and scholastic records. The two authors also emphasized the need to reconcile inconsistencies within and between data obtained from interviews and records.

Proximate Relationship

The second major question which the psychologist is typically asked to address is whether the damage (assuming it has been established) is due to the event in question. This is the legal issue of proximate cause. The assessment of proximate cause requires detailed inquiry into a complex array of determinants. The goal here is to establish a pre-incident baseline in order to ascertain whether impairments that may be present post-incident represent a significant change from what had been present prior to the incident. This requires the consideration of preexisting conditions, coexisting factors, and any other factor which may account for the emotional distress in total or in part. Weissman (1985) discussed these issues, stating that

> Predisposing trends, patterns and conflicts may include personality vulnerabilities, specific sensitivities, ungratified needs state, personality traits disorders, a precarious impulse-defense balance, and defective ego integration. . . . Apart from plaintiff's own version and retrospective reconstruction, information derived from independent sources is essential. Independent sources include all medical records (pre and post), vocational performance evaluations, educational and psychological records, and other case-specific pertinent documents. Additionally, independent sources include person's known to the plaintiff prior to the instant event. . . .
>
> In addition to the potentially determinant role of proximate and pre-existing factors is the role of coexisting factors. These pertain to circumstantial features in an individual's life (i.e., stressful events) which serve to promote, maintain, and protract the mental and emotional condition being claimed. Either pre-existing or coexisting factors may severally, or in combination, account for the claimed disorder. . . .A significant number of stressful events, such as death of a relative, financial loss, marital dysfunction, and crises with children often serve to cause and/or aggravate, and thus maintain and protract, clinical complaints and disorders quite apart from proximate factors in the instant event. (p. 143)

While these sources of information are similar to those included in the psychosocial evaluation discussed above, they differ in emphasis. Where the psychosocial evaluation focuses on the extent of damage, here the emphasis is on assessing the role of other factors which may account in some way for the distress being claimed. As in many areas of clinical assessment and diagnosis, no single source of data can adequately provide the clinician with the information necessary to draw a responsible conclusion. This is especially true when it comes to the task of ferreting out pre- and coexisting factors in attempting to assess the causal relationship between emotional distress and the event in question. A skilled clinician, however, working within the limits of the data, can often attest with reasonable certainty to the causal factors in a particular case.

Malingering

As stated above, the first and foremost task which a psychological expert encounters when consulting or testifying in a personal injury case where emotional distress is a factor, is to determine if a genuine mental disorder exists. The need for standard diagnostic criteria to establish the presence of an emotional disorder has been discussed above. Most diagnoses are based on a person's self report of symptoms, which presents an opportunity for a person to fake a mental disorder. It is imperative for the expert to be able to attest to the genuineness of the diagnosis and rule out the possibility of a feigned disorder.

One difference between the forensic setting and a typical clinical treatment setting, is the motive of the patient. People coming to a psychologist at a clinic or private office may deny or minimize the presence of emotional problems, or may seek help to alleviate their emotional distress as quickly as possible. While the presence of secondary gain is often a factor in the perpetuation of their condition, it is often not a conscious factor. The clinician approaches the individual from a stance of accepting at face value the client's report of symptoms and difficulties.

In the forensic setting, especially where monetary gain or compensation is at stake, the clinician must take into consideration the possibility that the person is exaggerating or feigning the symptoms or illness. This bears directly on establishing the presence of genuine emotional damage or distress. The psychological term for exaggerating real problems or fabricating illness is malingering. Malingering is defined in DSM-III-R (1987) as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (p. 360).

Qualitative Assessment

To substantiate the presence of a genuine emotional distress, malingering must be ruled out. Both a quantitative and a qualitative approach to the detection of malingering are required. The quantitative approach includes empirically based methods, primarily using standardized tests. The qualitative approach includes the psychologist's clinical skills and expertise in interpreting various sources of subjective data.

In detecting the malingerer, the interviewer must at times act more like a detective than the usual clinician. Lees-Haley (1985) described typical patterns which are helpful in identifying the malingerer. He identified two basic techniques used in this process: (a) psychological testing and (b) psychological evaluation interviews. Two techniques in the interview process are those of lengthening the interview and conducting the interview at a fast-pace. Lees-Haley asserted that lengthening the interview "creates more opportunities for deceivers to make mistakes, lose track of their role, or become tired and more transparent in their deception" (p. 69). Conducting the interview at a fast-pace denies the individual the opportunity to think through his or her answers and provides an opportunity for the deception to be exposed.

Lees-Haley (1985) also underscored the importance of the interviewer being familiar with the manner in which psychotics behave typically, because malingerers often deviate from these patterns. While malingering in personal injury cases rarely involves the presence of psychotic symptoms, the principle of looking for discrepancies between typical symptomatology and those being presented by the malingerer is important and most useful. Among the patterns of malingerers is the profession of "a long, chaotic list of problems that include exotic or improbable

combinations of symptoms" (Lees-Haley, 1985, p. 69). Malingerers' symptoms tend to be idiosyncratic rather than classic and may include symptoms they have heard of but may not be typical of a diagnostic category. The symptoms also tend to be full-blown rather than developed over time.

Malingerers often describe their symptoms differently than mentally ill people do and also tend to exaggerate their symptoms. They may claim hallucinations but can provide little specific information about them. Malingerers may also be more willing than most psychotics to admit their symptoms. In exaggerating their symptoms, they may appear more pathological than psychotics, omitting lapses into relatively normal functioning. Malingerers also tend to be obtrusive with their symptoms, unlike psychotics who often deny problems which malingerers are only too willing to admit. Lees-Haley (1985) also noted that malingerers tend to use language which expresses a different orientation from that of the mentally ill. This often reveals their having overlooked some of the subtleties of emotional expression, manner of relating to others, and unique reasoning found consistently in severe mental illness. However, malingerers often are more consistent than psychotics in their story or reporting of symptoms. For example, they may report their delusions in a correct manner but not live them out or act as if they believe their delusions are true as would a psychotic (Lees-Haley, 1985).

Drob and Berger (1987) emphasized the importance of ascertaining the motive of the suspected malingerer as well as determining if a real mental disorder exists along with classic signs of malingering. They warned that many persons who have classic signs of malingering are misdiagnosed as malingerers when there actually exists the presence of a factitious disorder or the combination of the disorder with malingering. Drob and Berger proposed a diagnostic system which they have found

useful in a forensic setting. Though their system has been developed for detecting malingerers in criminal cases, the diagnostic issues are relevant as well to the detection of malingering in civil cases.

Drob and Berger (1987) based their diagnostic matrix on three basic diagnostic questions:

> 1) Does the patient exhibit the 'classic signs' of feigning psychological symptoms? 2) Does the patient have a conscious motive for , or a least believe that he/she gains some advantage from being mentally ill? 3) Does the patient suffer from any actual mental defect or illness which would cause him to produce what appears to be voluntary symptomatology? (p. 521)

Based on the answer to these questions, a patient can be placed in one of four categories: (a) malingering, (b)uncooperative, (c) factitious disorder, or (d) mixed malingering and factitious disorder.

While a knowledge of the classic clinical signs of malingering is essential (Resnick, 1984), such signs may be missed in a standard clinical interview. A diagnostic system is needed to sift the wheat from the chaff. Drob and Berger (1987) proposed three avenues of inquiry in determining whether the classic signs of malingering are present. These are (a) the clinical interview, (b) psychological tests, and (c) ancillary and longitudinal observations. They also observed that individuals feigning mental illness in a forensic context usually attempt to simulate one or a combination of symptoms reflecting either psychosis, memory deficits, or depression/suicidality. While most malingerers will tend to cluster in one of these specific categories, it is not unusual for them to express symptoms across categories in an attempt to look disturbed.

Consistent with Lees-Haley (1985), Drob and Berger (1987) suggested that the

clinician frequently change the frame during the interview process. Examples of this would be to suggest that the interview is over in an attempt to engage in small talk, discussion of apparently trivial things, confrontation of the patient's behavior, and challenges to the patient's ego. They went on to warn that "one must remember that the genuine malingerer is acting a part and that the interviewer's task is to get him, at least for a moment, to forget or abandon the role" (Drob & Berger, 1987, p. 523).

Also consistent with Lees-Haley (1985), Drob and Berger (1987) emphasized the usefulness of psychological tests in diagnosing malingering. While the use of psychological tests will be discussed later, such testing offers some unique approaches specific to the determination of malingering. The approach of Drob and Berger is different from the quantitative analysis which most of the literature has addressed, and focuses rather on qualitative uses of psychological tests. They specifically discussed the use of the Bender Gestalt Visual-Motor Test, the Rorschach Inkblot Test, the Comprehension and Vocabulary subsections of the Wechler Adult Intelligence Scale-Revised, a parallel vocabulary test comprised of legal terms, and the 15 item memory test. In regard to the Bender Gestalt and Rorschach tests, they stated:

> We look for responses that are contradicted either by the patient's own behavior or within the exams themselves. Gross distortions or detailed elaborations on the Bender suggest malingering in patients whose other visual-motor behavior is neither grossly distorted nor elaborate. While many malingerers will reject a majority of the Rorschach plates, others will produce 'crazy' or distorted content which is contradicted by the benign formal features of their responses. (Drob & Berger, 1987, p. 525)

A technique Drob and Berger (1987) have employed on the comprehension subtest of the WAIS-R is to ask the even questions in normal order and the odd

questions in reverse order, labeling the first group easy and the latter group hard. Malingerers will often have a higher frequency of misses on the second group which is inconsistent with the degree of difficulty which they were able to pass in the first group. By juxtaposing a list of legal concepts with the WAIS vocabulary subtest, it can be determined if an individual is attempting to appear legally illiterate.

Lezak (1983) designed a fifteen item memory test which has been shown to be useful in the detection of malingering of memory loss or impairment. The test is designed to appear more difficult than it is, and employs only three or four basic ideas which are to be recalled.

The use of varied observations can be essential in the determination of malingering. Typically, clinicians see an individual for evaluation in one or two interviews, a situation which lends itself to malingering. While the malingerer can easily prepare for the interviews, sustaining the deception over an extended period of time, days or weeks is all but impossible. Any opportunity for observation over an extended period of time is beneficial in the detection of malingering because it provides the best opportunity for discovering the inconsistencies in behavior and mental status which are the hallmark of this syndrome (Drob & Berger,1987). The objective is to detect discrepancies between the data the individual is giving during testing and interviews, and the behavioral patterns observed outside the structured clinical setting. Observations made by others can be invaluable to this process. Additionally, the acquisition of a detailed history is emphasized, especially if ancillary observation is not possible.

The second diagnostic question employed by Drob and Berger is whether a motive exists for malingering, or, whether the person has anything to gain by faking an illness or disorder. In almost all cases of civil action, the individual stands to gain

substantially by demonstrating the presence of a disorder. In the broader forensic setting, it would be possible to encounter someone who is feigning an emotional disorder but has nothing to gain from such activity. Such a person would be placed in the category of uncooperative patient or in one that suggests the presence of a factitious disorder. However, the presence of a motive does not disqualify the possibility of a real disorder, even if classic signs of malingering are present. In such cases, careful attention to the third question is essential.

The third question has to do with discriminating whether there exists a legitimate disorder, that is, whether there are classic signs of malingering, or, whether there is a legitimate disorder concurrent with malingering. Drob and Berger (1987) suggested the following:

> Factitious disorder should be strongly considered in any case where the classic signs of malingering are present but an obvious or conscious advantage is not present. Indeed, it needs to also be considered in some situations where a conscious advantage is present. This is because conscious and unconscious trends frequently coincide and the dissemblance of mental disease is in such instances overdetermined. Our impression is that factitious disorder is underdiagnosed in forensic settings. There is a tendency is such settings to label all individuals who feign mental illness malingerers. (p. 531)

The point is that it is important to consider a legitimate diagnosis in some cases where classic signs of malingering are present.

Drob and Berger (1987) are most helpful in two areas: (a) focusing on the classic signs of malingering, and (b) encouraging the consideration of other possible diagnoses when these signs are present. Specifically, in the civil litigation area of forensic psychology, their work is most helpful in emphasizing the signs of malingering and in considering that in an individual case, malingering may be superimposed on some other disorder which may be related to the cause of action.

Literature on Malingering

While there exist various systems and approaches for attempting to detect malingering, there is very little evidence that malingering can be detected reliably (Ziskin & Faust, 1988). The problems created by falsification of either self-report symptomatology or psychological test performance have been discussed extensively in the professional literature. Goldstein (1980) urged caution on the part of the psychiatrist in evaluating the credibility of the complaining witness in a legal proceeding. Miller (1961) stressed that the straightforward motive of compensation may play a more significant role in an individual's exaggeration of disability than depth issues or psychopathology. Pugh (1973) made the bleak assertion that malingering is not only rampant in forensic psychiatry, but that psychiatrists are not even aware that they are being deceived. He attributed this to self-deception regarding the ability to detect malingerers. Hoffman (1986) brought out the added feature that an individual beginning a conscious deception may later begin to believe that his symptoms are real. Lindsey and Ozawa (1979) cited experimental evidence which indicates that psychiatrists may have difficulty discerning feigned schizophrenia. Beaber, Marston, Michelli, and Mills (1985) underscored the susceptibility of DSM-III diagnoses to feigned illness due to their reliance on subjective symptoms leaving a substantial possibility of diagnostic error. Likewise, Raifman (1983) warned of the validity of a diagnosis of post-traumatic stress disorder due to its exclusive reliance on self-reports that may be impossible to verify.

Rappeport (1982) emphasized the need for the psychiatrist to take a different role in the litigation situation. He suggested that the psychiatrist be more skeptical and not automatically or uncritically believing of what the patient says, always keeping in mind the possibility of malingering or exaggeration. Platt and Husband

(1986) noted that litigants may learn what is expected of them and react accordingly. These authors warned that reliance on the patient's self-report can sometimes make it difficult or even impossible for the clinician to detect malingering or the exaggeration of symptoms. Rogers and Cavanaugh (1983) pointed out potential problems when clinicians who normally function in helping roles are forced to deal with the adversarial role of determining honesty. Lees-Haley (1985) noted the malingerers are frequently more expert at lying than clinicians are at detecting them. McMahon (1983) asserted that it is nearly impossible to distinguish between hysteria and malingering, while Resnick (1984) maintained that no research has demonstrated the ability of mental health professionals to accurately detect malingering.

Rogers (1984) warned that the assumption many clinicians have that psychological tests cannot be distorted is contrary to the evidence. His review of the literature on psychological measures showed that all psychometric approaches are susceptible to dissimulation, and that neither the ambiguity of the method nor its intended goal prevents deliberate distortion of responses.

Davis (1979) found that subjects were able to falsify to a significant degree in both directions on the Beck Depression Inventory. Hare (1985) noted that prison inmates endorsed various self-report measures in ways inconsistent with information contained in institutional files. Mensch and Woods (1986) conducted a study which demonstrated that all of the subscales on the Luria-Nebraska Neuropsychological Battery are susceptible to faking.

Schacter (1986) examined the capacity of psychologists to distinguish between genuine and simulated memory deficits and found that the examiners were not able to distinguish between the groups above chance levels, even when the psychologists

expressed confidence in their evaluations. Brandt, Rubinsky, and Lassen (1985) developed a test to detect simulated amnesia. They found that malingerers tended to score significantly below chance levels on their measure.

In a study by Faust, Hart and Guilmette (1987), with children simulating memory deficits, one hundred percent of the malingerers were able to mislead the examiners on a neuropsychological battery of tests. Goebell's (1983) study, which claimed the ability to detect malingering on neuropsychological testing, must be viewed with great caution due to problems with the investigator's methodology. The conclusion is that the ability to make such discriminations in real life litigation cases is still questionable.

With regard to simulation on the Rorschach Ink Blot Test, Albert, Fox, and Kahn (1980) showed that a group of untrained subjects were able to successfully simulate paranoid schizophrenia without detection by a group of expert clinicians. Exner (1978) indicated that dramatic responses in combination with adequate form level on the Rorschach may suggest malingering. The findings of the Albert et al. study would tend to suggest that the simulation of severe pathology on the Rorschach is not easily detectable.

The Rosenhan (1973) study provided support for the position that serious mental disorder can be successfully faked and misdiagnosed in a psychiatric interview. In this study, clinicians in hospital settings made diagnoses on the basis of a single symptom presented by normal research confederates who sought and gained hospital admission. The study by Yochelson and Samenow (1976) as well as that by Pugh (1973) additionally support the view that psychiatrists are unable to detect reliably malingering in criminal populations. Sherman and Trief (1975) also found that patients were able to fake sickness in psychiatric interviews.

Quantitative Assessment

One instrument which appears to be better able to detect malingering is the Minnesota Multiphasic Personality Inventory (MMPI). Gough (1950) developed the F minus K index which is able to correctly classify 88% of authentic versus simulated profiles. Gough also developed the Dissimulation Scale-Revised which may also be helpful in identifying malingerers. In addition, the Wiener-Harmon Subtle-Obvious subscales may be useful in attempts to detect malingering. The use of these scales to detect malingering has been demonstrated in several studies (Anthony, 1971; Wilcox & Dawson, 1977; Heaton, Baade, & Johnson, 1978; Audubon & Kirwin, 1982).

Lees-Haley (1989a) suggested lower F and F-K cutoffs for personal injury evaluations versus other forensic populations. His rationale is that the personal injury litigant is less likely to fake the severe psychopathology necessary to elevate the F scale significantly. The personal injury claimant presents as quite different from the criminal populations who may be seeking a competency finding. Furthermore, the personal injury claimant frequently presents differently from the fake simulation population upon which the scales are based.

In recent years, studies based specifically on the detection of malingering have produced mixed results. Heaton et al. (1978) conducted a study utilizing the MMPI and a battery of neuropsychological tests with a group of malingerers and genuine head-injury patients. They found that the clinicians were able to detect the malingerers at a level from chance to twenty percent better than chance. They also found that there was no significant difference between examiners of different experience levels in their ability to detect malingering. The authors found certain qualitative differences in the response patterns of the malingering group. When applying statistical analyses to the data, the authors were able to develop cutoffs

which correctly classified all subjects in both groups.

A promising new device specifically designed for assessing the credibility of individuals making injury or illness claims has recently been developed by Lees-Haley (1989b). The Credibility Scale is a 100 item experimental true-false questionnaire which is basically self-administered and is standardized for use with adults with at least a sixth grade reading level. The premise is that individuals who do not give credible responses to general items have a higher probability of not being truthful in their claim of injury. While a low score on this measure does not lead to specific conclusions concerning why an individual may be feigning or exaggerating his or her complaint, it is consistent with the finding that the individual is not being straightforward or candid during the evaluation. This, in turn, raises doubt that the individual should be regarded as an objective, reasonable reporter of credible information.

In several unreplicated studies, the claim is made of the ability to detect malingering on neuropsychological tests (Benton & Spreen, 1961; Bruhn & Reed, 1975; Goebell, 1983). Johnson and Moses (1984) showed that inconsistent performance between tests or individual tasks requiring the same capacities is often inconsistent with brain injury and may in itself be a sign of malingering. Lezak (1983) and Bash and Alpert (1980) agreed that malingerers tend to overendorse items and have poorer performance on simple tasks that appear difficult than subjects with genuine deficits.

Wasyliw and Golden (1985) noted that malingering can be successfully sifted out in many cases during neuropsychological testing. They suggested that the clinician (a) be sensitive to internal inconsistencies, (b) utilize instruments developed to detect malingering such as those proposed by Lezak (1983), along with the above

mentioned MMPI subscales, (c) make use of extra-test data such as the client's activities outside of the testing situation, and (d) note carefully the examinee's general behavior and appearance.

Mendelson (1988) suggested that in the final analysis the determination of malingering is not within the scope of the clinician but is the task of the appropriate tribunal of fact. He asserted that the clinician needs to be sensitive to the possibility of malingering and utilize as many sources of information as possible in the determination of a diagnosis and opinion. He conceded nevertheless that the clinical interviewer is ultimately limited by the fact that he or she bases an assessment on the client's self-report of symptoms. Mendelson further warned that in the litigation setting, malingering is often diagnosed too quickly without considering a conversion type disorder, that is, an exaggeration of symptoms based on unconscious factors.

Psychological Testing in Forensic Psychology

Psychological testing is an indispensable element in determining the existence, prevalence, and etiology of emotional distress. It is an area in which the clinical psychologist is uniquely qualified. Psychological tests provide a statistical base of comparison of the individual to other groups of persons, be that normal groups who do not exhibit significant psychological impairment, or groups exhibiting specific pathology. The statistical basis upon which many tests are established as well as the body of research which support the validity and reliability as well as specific application of certain tests, give them a degree of objectivity which does not exist with a clinical interview alone.

While in many clinical settings objectivity is not a priority, because one is interested in understanding the patient's subjective point of view and distortions of reality are not always as crucial, in a forensic evaluation objective findings are paramount. Psychological tests often allow the clinician to attest with confidence that his findings are consistent with the prevailing evidence of research and professional standardized within the discipline. Korchin (1966) recognized the value of psychological tests in the opportunity they afford to permit focused observation under standard conditions. This helps to reduce subjective bias so that different individuals can be compared in more quantitative ways along relevant dimensions of psychosocial and neuropsychological functioning.

Weissman (1985) outlined the usefulness of psychological testing and its relevance to the assessment of emotional damages. He listed specific areas of relevance such as:

> 1) establishing baseline information which can be compared with what is known about the plaintiff's preincident functioning; 2) evaluating the plaintiff's status at various points in the recovery treatment; 3) differential diagnosis; 4) planning and guiding rehabilitative interventions; 5) making contingent predictions concerning future behavior. (Weissman, 1985, p. 144)

Blau (1984) stated that most testimony supported by psychological tests focuses on the psychological state of an individual. Psychological tests are especially useful in assessing intelligence, achievement, aptitude, personality traits and style, severe pathology, depression, stress, memory, and neurological damage or limitations. They may also be able to help ascertain if conditions are chronic in nature or situational.

As stated above, the primary issues which the psychological expert is asked to address are the determination as to the genuine existence of emotional distress and

the relatedness of the distress to the incident in question. Psychological tests used in conjunction with a clinical interview, extensive history, and additional records and observations, can be the deciding factor in a case because of their scientific basis. While there has been a proliferation of psychological tests in the past 75 years, the most commonly used instruments will be discussed here in terms of their usefulness, applicability, and limitations in the assessment of emotional distress.

The Minnesota Multiphasic Personality Inventory (MMPI)

The MMPI is the most widely used and researched psychometric instrument to date (Greene, 1980) and has been found to be useful in a wide variety of clinical settings. In fact, it would be difficult to find a clinical setting where it has not been used. The MMPI is especially useful in the forensic setting due to its almost unique ability to detect examinee malingering. It is useful as well in identifying individuals who display characteristics common to a variety of psychological disorders or disturbances.

The MMPI is a 566 item self-report questionnaire where subjects are given sentence stems and asked to reply if the statement is mostly true or mostly false for them. The more recent MMPI-2, published in 1990, has 567 items. The test is most frequently given in booklet form where subjects simply mark on a corresponding answer sheet true or false after each item. The subjects' responses are scored relative to three validity and ten clinical subscales which have statistical bases for rating. It is considered to be an objective test due to its statistical properties and standardization of administration and scoring. The scores on the various scales are displayed by means of a graph profile which is then interpreted clinically based on specific scale elevations as well as patterns between scales.

The three basic validity scales along with subsequently developed validity scales are able to determine if the profile is valid, that is, whether the individual is answering the questions in a frank and honest manner. The ten clinical scales provide evidence of an individual who has a statistically significant elevation of psychopathology in areas of somatic complaints, depression, hysteria, sociopathy, masculine/feminine traits, paranoia, anxiety/obsessive thinking, thought disturbance, introversion, and manic behavior. In addition to the basic scales, many special scales have been developed based on the same 566 or 567 items which are helpful in detecting more subtle maladjustment such as anxiety, repression, drug use, family conflict, hostility, phobias, work attitudes and treatment attitudes. By combining the basic and special scales, a clinician can accurately determine whether the person in question is exhibiting symptomatology consistent with psychological abnormality. Other objective inventory type instruments have been developed and can be useful to the forensic examiner but most have not had the extensive use and research of the MMPI to support the findings. The most popular of these would be the Sixteen Personality Factor (16-PF) and the Millon Clinical Multiaxial Inventory-II (MCMI-II).

Beyond being helpful in determining the existence of a genuine emotional disorder, the MMPI can offer indications as to personality make-up and whether the condition is reactive or more chronic in nature. This is important in addressing the forensic diagnostic questions relative to etiology of the disorder and its relation causally to the event in question. While the MMPI makes no claims to assessing the underlying cause of pathology, certain trends are more consistent with long-standing personality trait structure or style, while other findings may be consistent with state conditions which are caused by some external event(s).

The Rorschach Inkblot Test

The Rorschach is another instrument that has a long history of clinical utility. It has been considered a projective instrument in that it provides an ambiguous stimulus to the subject and historically was interpreted by the clinician in a highly subjective manner, with minimal standardization in the interpretive process. Exner (1978) has been the most successful in developing a standardized administration and scoring system and interpretation based on research and statistical principles which give it an objective test status. The Rorschach, when used according to the Exner system, is a highly potent and informative psychometric instrument.

The Rorschach is a set of ten cards containing stylized inkblots. The cards are presented to the subject one at a time and the subject is simply asked what the inkblot represents. The responses are recorded verbatim with little or no further instructions or prompting. After each of the ten cards is presented and the responses recorded, the inquiry section of the examination is conducted. During this part, each card is presented to the subject again. The first response is read to the subject as it was recorded and he or she is asked to explain what it was about the card which made it look that way. These second responses are recorded verbatim and further explanation or clarification is requested. After the administration, the responses to each card are coded and a structural summary is developed based on the frequency of certain aspects of responses. These scores are then compared to normative data which then permits certain interpretive hypotheses to be formulated regarding the individual. As with any psychometric instrument, qualitative interpretation of the data may add ideographic elements to the clinical assessment process.

The Rorschach is able to provide information about the individual in a broad range of areas. One of the strengths of the instrument is its ability to inform the

clinician of the subject's basic personality style. This involves a person's basic problem-solving style, the amount of psychological resources he or she may have available, how he or she handles stressful situations, and his or her receptivity to emotional experience. There are many nuances of an individual's style and functioning pattern about which the Rorschach can provide helpful information. The test can also provide estimates of the amount of stress the subject is under presently and the sources of stress, e.g., whether the stress is situational or internal. It can aid in verifying or corroborating whether a given subject is depressed, suicidal, psychotic, self esteeming, obsessive-compulsive, aggressive, feeling overwhelmed, likely to lose impulse control, emotionally stable, emotionally needy, or anxious.

Many of the aspects about the individual which the Rorschach measures are long-standing personality characteristics while others may be a function of situational stressors. This can be very useful in understanding the individual's basic personality organization which, along with a thorough history and corroborating information, may be useful in assessing his or her premorbid level of functioning. Situational readings can be useful in assessing the impact of external events in the individual's life and functioning.

Other Instruments

Other instruments, such as the projective Thematic Apperception Test, may be helpful in assessing an individual's personality style, way of viewing and dealing with others, as well as his or her emotional state of being. The limitation of such instruments is that they are highly subjective in their interpretation and thus dependent on the examiner's clinical and interpretive skills. They may not stand up well to the criteria of scientific certainty that is often necessary in legal testimony.

Additional instruments of a projective type include the Sentence Completion, and Draw-A-Person tests. The latter is not so frequently employed in a legal or forensic context.

While the MMPI and Rorschach are measures of personality as a whole and of more or less global functioning, several objective instruments can be helpful in assessing specific symptomatology and areas of functioning. Depression, for example, is a diagnosis which is common in emotional distress litigation. The Beck Depression Inventory is a simple 32-item true or false instrument which measures the presence of depression and its relative severity based on the individual's self-report of symptomatology via endorsement of the given items. While the power of the instrument is in its quantitative measure, a qualitative examination of the items endorsed can also be very helpful. However, it has no deception measure and, because of the face validity of the items, can therefore be easily faked. There are literally thousands of short inventory tests such as the Beck Depression Inventory, most having normative data for specific populations.

Anxiety is another frequently encountered diagnostic category and a specific measure for anxiety is appropriate in the litigation setting. Like the depression inventory, most anxiety scales are based on self-report and therefore susceptible to falsification . The Clinical Anxiety Scale, the Hamilton Anxiety Scale, and the Taylor Manifest Anxiety Scale are useful instruments for assessing the presence of clinical anxiety in an individual.

Horowitz, Wilner, and Alvarez (1979) developed the Impact of Event Scale for measuring the effects of specific life events which produce psychological symptomatology. This reliable self-report scale classifies the effects of stress into two major categories, namely, intrusion and avoidance.

> Intrusion refers to the penetration of thoughts, images, feelings, and dreams and to a variety of repetitive behaviors that are distressing to the individual. Avoidance refers to the tendencies of psychic numbing, conscious denial of meanings and consequences, behavioral inhibition, or counterphobic activities related to the stressful life event. (Schwarzwald, Solomon, Weisenberg, and Mikulincer, 1987, p. 251)

This instrument can be helpful in determining the psychological mechanisms being utilized to cope with a trauma, and by inference, gaining a better understanding of the stage of resolution achieved at a particular point in time. Again, due to its self-report and face validity characteristics, it is susceptible to faking unless the examiner can obtain repeated measures and evaluate the changes over time in light of other non-test data.

A number of questionnaires can also be helpful in creating a clinical picture of an individual who is pursuing litigation. Examples are the Wahler Physical Symptoms Inventory and the Personal Problems Checklist. While these are not standardized psychometric instruments per se, they provide useful data in addition to the objective instruments mentioned above and a thorough history together with, previous records and data obtained as part of the clinical interview. They can be helpful in assessing the consistency between reports of problems and symptoms which are then factored into the final evaluation of the individual's condition and genuineness of distress. While an individual may be successful in malingering on a single instrument, multiple instruments provide an opportunity to either identify the malingerer or confirm the presence of a genuine disorder or condition.

Neuropsychological Testing

Neuropsychological assessment has advanced significantly in the past twenty

years and has achieved increased usefulness in the area of forensic evaluations (Wasyliw & Golden, 1985). It is especially useful in the detection of the functional effects of brain injury which may not be diagnosed by traditional medical techniques. While this bears more on the area of physical versus emotional damage, it is an area which warrants mentioning here in that many of the issues are shared and often coexist.

Neuropsychological assessment can be useful in differentiating between neurological damage and emotional disorders. Many neurological injuries may have behavioral symptomatology which mimics or closely resembles functional disorders. Furthermore, it is not impossible for a neurological injury to be superimposed on underlying personality pathology or to lead to an exacerbation of pre-existing personality traits to the point that they become debilitating. Finally, there are frequently secondary emotional effects to neurological damage which include emotional reactions to limitations as well as the emotional impact on the family of the accident victim (Lynch, 1982). Wasyliw and Golden (1985) stressed the importance of sifting out these interacting factors. They also affirmed the need to determine the psychological importance of the neurological injury to the patient in differentiating neurologically based personality problems from underlying personality pathology. It would be safe to say where neurological damage is suspected, underlying or reactive personality issues must be ruled out. Likewise, where a functional or personality disorder is suspected, neurological factors should be considered as well. The neuropsychological component in the assessment of emotional distress is important and needs to be included where clinical observations, history, or medical findings are suggestive of possible neurological impairment.

Testing Standards

Finally, Blau (1984) brought forward several issues that should be considered when using psychological tests in a forensic evaluation. Standardized administration and scoring procedures should be utilized and any deviation or factors interfering with optimum performance should be noted. The examiner should be prepared to justify and explain whatever cut-off criteria are used. The results should be explained in a manner understandable to the attorneys, the judge, and the jury. The examiner should be prepared to justify the appropriateness of the normative data used relative to the subject. Care should be taken in generalizing test validity from one situation to another. The examiner must be clear as to whether conclusions are based on clinical versus statistical interpretations of the tests.

Psychological tests can be vitally important in the process of assessing emotional distress. However, this must be done within the limitation of each instrument. Tests are helpful in confirming the presence of psychological distress and in providing corroboration of the diagnosis. The process of differential diagnosis not only among emotional conditions, but between neurological and functional conditions is another feature of tests. They are helpful in establishing the genuineness of the disorder and the detection of malingering. Finally, they are helpful in providing a picture of underlying personality structure which may make some individuals more vulnerable to particular types of stressful experiences. Differentiating chronic versus acute conditions may bear on the question of pre-existing conditions and the causal relationship between the disorder and prior events.

Conclusion

Civil litigation involving claims for damages from emotional distress is a reality in our society today. Psychiatric and psychological testimony on these matters has established itself as crucial in such litigation. No other discipline is better qualified to testify as experts in these matters than clinical psychologists. The psychologist is asked to determine if emotional damage is present, if the damage is genuine, and to what extent it was caused by the event in question.

To answer these questions, the psychologist must use a wide range of approaches, instruments and techniques to give a determination and opinion with reasonable certainty. These approaches include (a) clinical interviews, (b) extensive history-taking, (c) examination of previous records and corroboration of their information, and (d) psychological testing. Each of these approaches has limitations and there exists vulnerability to the malingering litigant. The assessment of emotional distress presents unique problems because of the context of the setting and circumstances, primarily the existence of potential gain for the plaintiff. This differs from the typical clinical setting in that it is assumed that persons are truthful about their problems and want help. Subsequently, most clinical techniques and instruments as well as the clinician's training is based on the assumption of truthfulness. This differs from the forensic setting where there may exist a high degree of motivation to feign the illness. This demands that the clinician be sensitive to the differences between the clinical and forensic setting, and aware of the legal issues as well as the limitations of his procedures.

Finally, the importance of standardized diagnostic criteria, approaches to assess pre- and coexisting factors as well as psychological testing has been discussed. While

problems and limitations exist, a skilled clinician with a comprehensive approach can in many cases attest with confidence to the status of a given person who claims emotional distress. Further research and development is needed in the area of malingering, specifically in detecting it on instruments presently available as well as in developing instruments specifically for its detection. Also, there is limited ability presently to tie a disorder to its cause and to systematically or empirically account for pre- or coexisting factors. Therefore these factors in assessment are left largely to the psychologist's clinical skills and subjective appraisal. At the same time, these are areas where perhaps we will always be required to rely on a certain degree of subjectivity. The assessment of emotional distress is an attempt to quantify the human being and condition, a task which may not be entirely possible. Assessment also steps into the philosophical arena in respect to the issue of suffering. There is a certain attitude which is implicitly expressed by the prevalence of litigation that people should not suffer and if they do, they are owed compensation for their suffering. Obviously, an individual should be held responsible for his or her intentional or negligent damage to another party. However, uncompensated suffering appears also to be one of the realities of life. Perhaps the present flurry of litigation, finger-pointing and entitlement may at times be an attempt to deny the realities and price of existence.

REFERENCES

Allodi, F. (1974). Accident neurosis: whatever happened to male hysteria. Canadian Psychiatric Association Journal, 19, 291-295.

Albert, S., Fox, H. M., & Kahn, M. W. (1980). Faking psychosis on the Rorschach: Can expert judges detect malingering? Journal of Personality Assessment, 44, 115-119.

Anthony, N. (1971). Comparison of client standard exaggerated and matching MMPI profiles. Journal of Consulting and Clinical Psychology, 36, 100-103.

Audubon, J. J., & Kirwin, B. R. (1982). Defensiveness in the criminally insane. Journal of Personality Assessment, 46, 304-311.

Bash, I., & Alpert, M. (1980). The detection of malingering. In F. Wright & C. Ricber (Eds.), Forensic psychology and psychiatry (pp . 86-99). New York: The New York Academy of Sciences.

Beaber, R. J., Marston, A., Michelli, J., & Mills, M. J. (1985). A brief test for measuring malingering in schizophrenic individuals. American Journal of Psychiatry, 142, 1478-1481.

Benton, A. L., & Spreen, O. (1961). Visual memory test: The simulation of mental incompetence. Archives of General Psychiatry, 4, 79-83.

Blau, T. H. (1984). Psychological tests in the courtroom. Professional Psychology: Research and Practice, 15(2), 176-186.

Brandt, J., Rubinsky, E., & Lassen, G. (1985). Uncovering malingered amnesia. Annals of the New York Academy of Science, 44, 502-503.

Bruhn, A. R., & Reed, M. R. (1975). Simulation of brain damage on the Bender-Gestalt test by college students. Journal of Personality Assessment, 39, 244-255.

Cartwright, R. E., & Kassel, B. A. (1988). Evaluating emotional damages: The role of psycho-social assessments. Trial, 24, 77-80.

Davis, T. W. (1979). "Faking good" and "faking bad" on the Beck Depression Inventory and variables which might contribute to "faking" by adult clients of a community health center. Dissertation Abstracts International, 39, 7235A-7236A. (University Microfilms No. 79-12786).

Diagnostic and statistical manual of mental disorders (3rd ed., rev.)(1987). Washington, DC: American Psychiatric Association.

Dillon v. Legg, 68 Cal. 2d 728 (1968).

Drob, S. L., & Berger, R. H. (1987). The determination of malingering: A clinical-forensic approach. The Journal of Psychiatry and Law, 15(4), 519-536.

Exner, J. E., Jr. (1978). The Rorschach comprehensive system, Volume 2: Current research and advanced interpretation. New York: Wiley.

Faust, D., Hart, K., & Guilmette, T. J. (1987). Pediatric malingering: The capacity of children to fake believable deficits on neuropsychological testing. Journal of Consulting and Clinical Psychology, 56(4), 578-582.

Frye v. United States, 293 F. 103 (D.C. Cir. 1923).

Goebell, R. A. (1983). Detection of faking on the Halstead-Reitan test battery. Journal of Clinical Psychology, 39, 731-742.

Goldstein, R. L. (1980). Credibility and incredibility: The psychiatric examination of the complaining witness. American Journal of Psychiatry, 137, 1238-1240.

Gough, H. G. (1950). The F minus K dissimulation index for the MMPI. Journal of Consulting Psychology, 14, 408-413.

Greene, R. L. (1980). The MMPI: An interpretive manual. New York: Grune & Stratton.

Hare, R. D. (1985). Comparison of procedures for the assessment of psychopathy. Journal of Consulting and Clinical Psychology, 53, 7-16.

Heaton, R., Baade, L., & Johnson, K. (1978). Neuropsychological test results associated with psychiatric disorders in adults. Psychological Bulletin, 85(1), 141-163.

Hoffman, B. F. (1986). How to write a psychiatric report for litigation following a personal injury. American Journal of Psychiatry, 143, 164-169.

Horowitz M. J., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218.

Jenkins v. United States, 307 F. 2d 637 (D.C. Cir. 1962).

Johnson, G. L., & Moses, J. A. (1984). An empirical evaluation of the decision tree procedure for the Luria-Nebraska Neuropsychological Battery. International Journal of Clinical Neuropsychology, 6, 98-102.

Korchin, S. J. (1966). Modern clinical psychology. New York: Basic Books.

Lasky, H. (1980). Psychiatry and California Workers' Compensation laws: a threat and a challenge. California Western Law Review, 17, 1-25.

Lasky, H. (1983). The usable psychiatric report - workers' compensation style. In R. Cahan & B. Cahan (Eds.), Workers' compensation psychiatric evaluation program syllabus (pp. 124-132). Los Angeles: Southern California Psychiatric Society.

Lees-Haley, P. R. (1985). Psychological malingerers. Trial, 21, 68-69.

Lees-Haley, P. R. (1989a). MMPI F and F-K scales: Questionable indices of malingering. American Journal of Forensic Psychology, 7(1), 81-84.

Lees-Haley, P. R. (1989b). Credibility scale manual. Athens, GA: E & F.

Lezak, M. (1983). Neuropsychological assessment (2nd ed.). New York: Oxford University Press.

Lindsey, D., & Ozawa, M. N. (1979). Schizophrenia and SSI: Implications and problems. Social Work, 24, 120-126.

Ludwig, A. M. (1982). "Nerves": a sociomedical diagnosis...of sorts. American Journal of Psychotherapy, 36, 350-357.

Luria, A. R. (1972). The man with a shattered world. Chicago: Henry Regnery.

Lynch, W. J. (1982). Emotional consequences of brain injury. In L. E. Trexler (Ed.), Cognitive rehabilitation: Conceptualization and treatment (pp. 63-76). New York: Plenum.

Magruder (1936). Mental and emotional distrubances in the law of torts. Harvard Law Review, 49, 1033.

McMahon, E. A. (1983). Forensic issues in clinical neuropsychology. In C. Golden & P. J. Vicente (Eds.), Foundations of clinical neuropsychology. New York: Plenum Press.

Mendelson, G. (1988). Psychiatric aspects of personal injury claims. Springfield, IL: Thomas.

Mensch. A. J., & Woods, D. J. (1986). Patterns of feigning brain damage on the LNNB. The International Journal of Clinical Neuropsychology, 8, 59-63.

Miller, H. (1961). Accident neurosis. British Medical Journal, 1, 919-925.

Molien v. Kaiser Foundation Hospital, 27 Cal. 3d 916 (1980).

Nussbaum, K. (1973). Objective assessment of degree of psychiatric impairment: is it possible? Johns Hopkins Medical Journal, 133, 30-37.

Paugh v. Hanks, 451 N.E. 2d 759 (Ohio, 1983).

People v. Davis, 62 Cal. 2d 791 (1965).

Perlin, M. L. (1980). The legal status of the psychologist in the courtroom. Mental Disabilities Law Review, 4(3), 194-200.

Perr, I. N. (1984). Medical and legal problems in psychiatric coding under DSM and ICD systems. American Journal of Psychiatry, 141, 418-420.

Platt, J. J., & Husband, S. D. (1986). Post-traumatic stress disorder in forensic practice. American Journal of Forensic Psychology, 4, 29-56.

Prosser, W. L. (1971). Handbook of the law of torts. St. Paul: West.

Pugh, D. (1973). The insanity defense in operation: A practicing psychiatrist views Durham & Brawner. Washington University Law Quarterly, 87-108.

Raifman, L. J. (1983). Problems of diagnosis and legal causation in courtroom use of post-traumatic stress disorder. Behavioral Sciences and the Law, 1(3), 115-130.

Rappeport, J. R. (1982). Differences between forensic and general psychiatry. American Journal of Psychiatry, 139, 331-334.

Resnick, P. J. (1984). The detection of malingered mental illness. Behavioral Sciences and The Law, 2(1), 21-38.

Ricky v. Chicago Transit Authority, 457 N.E. 2d 1 (Illinois, 1983).

Rodrigues v. State, 52 Hawaii 156, 472 P 2d 509 (1970).

Rogers, R. (1984). Toward an empirical model of malingering and deception. Behavioral Sciences and the Law. 2(1), 93-111.

Rogers, R., & Cavanaugh, J. L., Jr. (1983). Nothing but the truth...a reexamination of malingering. The Journal of Psychiatry and Law, 11, 443-459.

Rosenhan, D. L. (1973). On being sane in insane places. Science, 179, 250-258.

Schacter, D. L. (1986). On the relation between genuine and simulated amnesia. Behavioral Sciences and the Law, 4(1), 47-64.

Schwarzwald, J., Solomon, Z., Weisenberg, M., & Mikulincer, M. (1987). Validation of the Impact of Event Scale for psychological sequelae of combat. Journal of Consulting and Clinical Psychology, 55(2), 251-256.

Schumann, D. W. (1986). Psychiatric and psychological evidence. New York: McGraw-Hill.

Sherman, N., & Trief, P. (1975). Impression management in the psychiatric interview: Quality style and individual differences. Journal of Consulting and Clinical Psychology, 43, 867-871.

Smith, A. R. (1984). Victims of emotional distress: What tests should determine recovery? Trial, 20, 34-39.

Terman, L. M. (1931). Psychology and the law. Los Angeles Bar Association Bulletin, 6, 142-153.

Wasyliw, O. E., & Golden, C. J. (1985). Neuropsychological evaluation in the assessment of personal injury. Behavioral Sciences and the Law, 3(2), 149-164.

Weissman, H. N. (1985). Psycholegal standards and the role of psychological assessment in personal injury litigation. Behavioral Sciences and the Law, 3(2), 135-147.

White, G.E. (1980). Tort law in America. New York: Oxford University Press.

Wigmore, J. H. (1909). Professor Muensterberg and the psychology of testimony. Illinois Law Review, 3, 399-445.

Wilcox, P., & Dawson, J. G. (1977). Role play and hypnotically induced simulation of psychopathology on the MMPI. Journal of Clinical Psychology, 33, 743-745.

Yochelson, S., & Samenow, S. (1976). The criminal personality. New York: Jason Aaronson.

Ziskin, J., & Faust, D. (1988). Coping with psychiatric and psychological testimony. Marina del Rey, CA: Law and Psychology Press.

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